



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

MARCUS HAYES, DC  
PO BOX 198  
BARKER, TX 77413-0198

#### **Respondent Name**

FEDEX FREIGHT EAST INC

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-2804-01

#### **MFDR Date Received**

MAY 1, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "This is not a case of medical necessity per peer review finding(s). The treating doctor, Ed Davis, DPM, did not agree with the findings of the previous DD's determination. Since Dr. Davis is not certified to perform MMI/IR exams, Dr. Davis had to refer [injured employee] to a doctor certified to perform this particular evaluation."

**Amount in Dispute:** \$650.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2012	99456-WP	\$650.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative code §134.204 sets out the guidelines for reimbursement of workers' compensation specific services rendered on or after March 1, 2008.
3. 28 Texas Administrative Code §133.20 sets out the guidelines for medical bill submissions by a health care provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 19, 2012

- 193 – Original Payment Decision is being maintained. This claim was processed properly the first time
- 216 – Based on the findings of a review organization.

Explanation of benefits dated April 5, 2012

- 216 – Based on the findings of a review organization.
- W1 – Workers Compensation State Fee Schedule Adjustment.

### **Issues**

1. Did the requestor bill CPT code 99456 in accordance with 28 Texas Administrative Code §134.204?
2. Did the requestor append the required modifiers to CPT code billed?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §134.204 (j)(1)(A), (B) & (E) state, "(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor." 28 Texas Administrative Code §134.204(j)(3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." 28 Texas Administrative Code §134.204(j)(4)(C)&(i-iii) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (1) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4<sup>th</sup> edition is used. (II) If full physical evaluation, with range of motion is performed: (a) \$300 for the first musculoskeletal body area; (b) \$150 for each additional musculoskeletal body area. (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.
2. Review of the submitted documentation finds that the requestor submitted a bill using CPT Code 99456-WP for a MMI/IR exam. 28 Texas Administrative Code §133.20 (c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitted medical bills. The Division concludes that the requestor did not append all appropriate modifiers required in accordance with 28 Texas Administrative Code §134.204 (j).
3. In accordance with 28 Texas Administrative Code §133.20 and 28 Texas Administrative Code §134.204 reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$ 0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

### **Authorized Signature**

_____	_____	02/12/2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information

specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**